VISIT DEFINITION CLARIFICATION

1. QUESTION: When our Dietician goes to see our Inpatients on the Wards and takes a count for weighted Procedures to be reported on SAS 014, this same instance should not be reported as an 'Inpatient Visit' on SAS 002/003, correct? In what instance would she/he count an encounter with an Inpatient as an 'Inpatient Visit'?

ANSWER: That is correct, you count for the weighted procedure on SAS 014; however, you do not report this workload as an inpatient visit on SASs 002/003. The definition of an inpatient visit is: "Each time an inpatient is seen in an outpatient clinic within the admitting MTF on a consultative basis."

2. QUESTION: Have we been provided the change that the Unified Business Utility (UBU) gave to the visit definition that could make some items such as Advice Nurse visits an "Occasion of Service"? You indicated in New Bulletin 13 that you would be providing further guidance when and if the UBU's recommendations were approved.

ANSWER: The final definition of a visit can be found on the following web site: http://www.tricare.osd.mil/org/pae/ubu/default.htm

3. QUESTION: Currently when we need skin problems analyzed, we refer the patients' downtown, and the results are sent back to the referring provider. Eisenhower had agreed to give us a special camera to do this in house if we could provide the space and the personnel to staff it. Here is the scenario. We take a picture of the affected area of the patient and transmit it to Eisenhower along with a transcribed provider's note. A specialist at Eisenhower reviews the picture and sends the diagnosis back to the provider who requested the consult. We are still working out the details; however, the basic steps are:

1. Convert an examining room in surgery clinic into the Tele-Derm room.
2. Staff it with a RN and necessary support staff. They will receive necessary training.
3. Operate a couple of times a week, half a day each.
4. RN will be responsible for taking the picture, transmit to Eisenhower, and distribute the diagnosis to the requesting provider. She will also ensure proper entry into CHCS.

I plan to have the associated expenses for this service (room, labor, supplies, etc) step down to the clinics that send the patient for Tele-Derm.

a. What kind of workload would this service generate? Some at the health center would like to see visit count out of this. But under the definition of 'VISIT', I don't think we could justify that.

b. Could this be considered ancillary and report the number of patients and/or minutes of service?

c. Could we generate some kind of workload out of this?

d. What MEPRS code? BAX (because dermatology falls under internal medicine), BBX (because will be located in surgery clinic and staffed by surgery personnel), DDZ (special procedure services not elsewhere classified)?

ANSWER: The Unified Biostatistical Utility (UBU) received an issue on Tele-derm which provided definitions for specific activities within Tele-derm that would either generate a visit count, a procedure count or non-count workload. However, this issue was not a priority and since has been dropped by the UBU. However, the Army MEPRS Program Office will recommend this issue be placed back on the UBU's agenda.

However, based upon the visit definition, the only countable workload is the ambulatory minutes of service. There is no new MEPRS code required based upon this concept.

4. QUESTION: How are other installations handling School Health Screening

a. Do they show a visit in CHCS?
b. What FCC do the physicians put their time against?
c. Is comp time given to all that participate?

ANSWER: School health screenings are normally considered occasions of service not visits. Time spent conducting school health screenings should be recorded against the Functional Cost Code/MEPRS Code – FAZP. The appropriate personnel at the MTF should address approved compensatory time. AMPO cannot dictate whether compensatory time should be given to everyone who participates. School health screenings should not be confused with school physicals, which are countable visits.

5. QUESTION: How do we account for readings performed outside the EKG Clinic**:**

a. EKG readings performed in outlying clinics
b. EKG readings performed Another MTF
c. EKG readings performed on economy

ANSWER: It is normally an internist that reads the EKGs whether he/she is at the parent facility or not. Time spent reading EKGs that were performed in the EKG Clinic should be recorded against the Functional Cost Code (FCC)/MEPRS Code DDA. However, according to ASAM (Automated Staffing Assessment Model) the time spent reading EKGs where the EKG was actually performed in other clinics are factored into the benchmark. ASAM provides credit to the clinic that's reading the EKG, and that clinic varies from MTF to MTF. There's no time recorded against DDA in those clinics, so the provider must inform the ASAM analyst that they spend a percentage of their time reading EKGs. Since EKGs readings are not captured in CHCS, the clinic would have to keep some manual record of the number of readings performed.

6. QUESTION: Do we count Optometry Technician workload as visits?

ANSWER: It depends on exactly what the optometry technician is doing**.** Visits can be counted for the technicians when they perform such things as driver's license screenings, depth perception tests, and the vision portion of a medical exam (soldier is sent to Optometry for the eye test by Medical Exam). Eye glass fittings, pre-testing for the physicians; however, do not count as visits.

7. QUESTION: Should Hearing Conservation visits remain "reportable"?

ANSWER: The current policy in the DOD 6010.13-M states the performance factor for the Hearing Conservation Program is a "visit" and therefore, will remain as reportable visits. The following is also provided:

It has always been the understanding that the techs are an extension of the provider. While they are not credentialed themselves, they are in effect credentialed under the provider. Specifically regarding hearing conservation, techs are trained to recognize the different types of hearing loss and educate and inform the patients as to degree of hearing loss the patient may have. Furthermore, most 91BP2s (Audiology/ENT techs) are trained and educated to actually perform hearing evaluations independently from the provider. In other words, most of the P2 Audiology techs have their own patient schedules separate from the Audiologist's schedule, with the Audiologist acting in the capacity of reviewing/monitoring hearing tests. For hearing conservation visits, the Audiologist only acts as a reviewer/consultant and does follow-up testing on patients that present problems. Hearing conservation technicians receive special, certified training to perform these tests. So, even though the Audiologist may review the tests, the techs do have to practice some form of independent judgement. Most hearing conservation techs (beside 91BP2s) are not trained to diagnose necessarily, but are trained to recognize problem areas when it comes to referring for further evaluation. However, hearing conservation visits have always been justified and counted as "reportable visits" as long as the clinic personnel were performing the tests.

8. QUESTION: Does an audiologist capture all visits, or are techs capturing some visits independently? If so, are the techs privileged and credentialed to do so?

ANSWER: A privileged provider is defined as follows:

PRIVILEGED PROVIDER: A healthcare professional granted permission to provide medical, dental, and other patient care in the granting facility within defined limits, based on the individual's education, professional license, experience, competence, ability, health, and judgment. This provider has had their qualifications reviewed by the credentials committee and their scope of practice defined.

The other issue is that screening exams are not visits. If technicians are performing a hearing-screening exam, then it should not be considered a visit.

9. QUESTION: How do we account for workload in Medical Exam (MEPRS Code BHB)?

Our ADS representative has written guidance from PASBA that PART I of Physical Exams will not be counted as a visit and that is what she is telling all clinics. They have started to change that appointment to NON-COUNT in CHCS.

PART I of Physical Exams is performed by 91Bs. Are we supposed to follow PASBA guidance and consider PART I as NON-COUNT workload?

ANSWER: Based upon the interpretation of the visit definition, this is correct. The Part I of the physical is a non-count and the Part 2 is a visit count. The physician should record Part 2 of the physical under the BHB Functional Cost Code (FCC). This can/will assist in the determination of support staff.

10. QUESTION: We have a clinic called Public Health and Education Center (PHEC - formerly community health clinic), BHFA. Sometimes they hold various types of health fair for the Redstone community. The next event includes osteoporosis screening, and many are expected to be DACs and the contractors who work at Redstone. The clinic had been told by PAD that they CANNOT include these civilians in the visit count because the only clinic authorized to see these categories of patients and enter the data in CHCS for visit count is Occupational Health Clinic. The PAD even recommended that perhaps PHEC give the visit counts to Occupational Health Clinic. The PHEC personnel assured me that the every test would be documented in patient records and entered in CHCS to ensure the visit count is valid. Is PAD correct in pointing out that Occupational Health Clinic is the only clinic that can enter civilians and contractors in the CHCS and receive credit for visit count?

ANSWER: Health Fairs should not be reported in the clinic as visits, the personnel time should be reported in the FCC/MEPRS Code - FBBP. The real issue for PAD is that if these individuals were not authorized beneficiaries then MSA would generate a bill for these patients as a "Civilian Emergency". This is not a good public relations thing to do.

11. QUESTION: I have a question about how we are tracking our ER visits. We have several GMOs working in the ER, should their visits be BHA* or BIA. Also, regardless of specialty, when a provider goes to the ER to provide patient care the visit should reflect the provider's specialty of care.

ANSWER: According to our credentials coordinator General Medical Officers (GMO) and all other doctors could provide emergent care. Emergency Physicians complete a 3 to 4 year residency and receive privileges as Emergency Physicians, BIA. Across the board, all docs that provide care in the ER are coding the visit as Emergency Medical Care, BIA. The location of care does not dictate the specialty of care provided.

Based on the information provided, any workload generated within the ER, to include that generated by a GMO, should be credited to a "**BIA**" account. The ER is not a multi-specialty clinic, IAW DOD 6010-13M.

12. QUESTION: In the past we have reported Pain Management and APV Pain Management clinic visits. It has come to our attention that PAD is no longer counting APV Pain Management. When asked about this, they tell me that In October 1999 they were instructed by MEDCOM coding personnel that the following were not to be considered as APVs:

PAIN MANAGEMENT
DIALYSIS
CHEMOTHERAPY

When we started our Pain Management clinic, the way we had it set up was when the patient was referred to Pain Management for chronic pain the Anesthesiologist would receive a clinic visit (BBLA), he would assess the patient and set up a treatment plan. If the doctor wanted to do an epidural steroid injection or epidural blood patch injection he would schedule the patient for an APV and we would receive an APV visit. When we first started APVs we had to come up with a list of things that would be considered APVs. The epidural steroid injection and epidural blood patch injection were on the list.

ANSWER: We've researched for any change to the APV guidance from MEDCOM. We are not aware of any changes to the basic memo dated Jan99, titled Ambulatory Procedure Visits (APVs). This memo specifically restricts "Ongoing or recurrent treatments such as chemotherapy, dialysis, and blood transfusions or ancillary procedures such as echocardiograms and stress tests should not be classified as APVs." The MEPRS Program Office has not received any change to this. If the Pain Management has been expressly prohibited by MEDCOM coding personnel, then a copy of their document should be obtained. In addition, based upon the above scenario, the pain clinic would not be generating an APV visit, but the physician that referred the patient would generate an APV because they're performing the procedure.

13. QUESTION: Workload standardization. Is there going to be standard definitions or count and non-count.

ANSWER: Workload standardization is a concept that has no automation to support the process. Funding must be approved before this can be implemented.

14. QUESTION: How do "we" plan to account for non-count visits to non-providers now that we will start using the DOD Standardized Appointment Types (These are specifically for PROVIDERS only) i.e. RN Triages, Advice lines, patient education, etc.

ANSWER: This is a question that the MEPRS Management Improvement Group (MMIG) proposed to the Appointment Standardization team and are awaiting an answer. To date, a clinic is profiled as count or non-count, and then each provider within the clinic is profiled. As far as the AMPO's been informed, the appointments by RNs would be profiled as non-count under that specific clinic.

15. QUESTION: Currently our Advice Nursing Center uses EM code 99371 (Phone Consult Brief) and appointment type Tele-Con to account for the ADS encounters. According the UBO, nurses can only use EM code 99211. Is this correct?

ANSWER: You already have the basis for this in writing. It is in the new ADS Coding Guidelines, paragraph 3.1.4.2. This paragraph states that Non-privileged Providers can use only 99211 and may not mark the telephone consultation indicator. Formerly this was an exception for the Advice Nurse, but that has been eliminated. So the Advice Nurse now has a choice: 1) makes this encounter a walk-in and use 99211) or 2) don't report it in ADS. We are trying to "clean up" ADS and nurses making telephone calls DO NOT qualify as making a telephone consultation. Now if the MD calls the patient, that counts as a telephone consult.

16. QUESTION: What exactly is the ADS/CHCS metric supposed to measure and how will a facility ever reach 100% compliance? They measure two different things, visits and encounters. Example, our community care clinics will be doing a lot of triage to increase access to the providers. These triage encounters will generate an ADS sheet, and will be put in CHCS under a non-count appointment type, which will decrease percentage away from 100%.

ANSWER: The metric measures the number of ADS encounters in relationship to the number of visits reported on the WWR. If the number of encounters is greater than the number of visits, then the facility is 100%. The key to getting 100% is making sure that each ADS encounter is complete, along with CHCS End of Day processing.

17. QUESTION: Can telephone consults be counted for non-privileged providers?

ANSWER: Non-privileged providers cannot count telephone consults as reportable workload.

18. QUESTION: We have a work center called Public Health and Education Center (another name for community health clinic), MEPRS code BHFA. They frequently conduct health classes, e.g., diabetics. A diabetic class lasts all day, and it is divided into three segments. Three PHEC nurses teach the class, each taking a segment. There is a patient-provider encounter during the class which results in information entered in medical record, thus a countable visit. They've assured me that the visit criteria is met.

Now here is the issue. I mentioned that the visit criteria (DOD 6010-13) for group session states that "Only the primary provider of group sessions may count one visit per patient if the criteria are met," Therefore a class of 10 would result in 10 visits. I've been given an argument that this is an all day class combing three segments into one class, each segment lasting a good while, that each nurse should be allowed to count 10 visits for her segment, for a total of 30 visits for this class. Another argument was that the diabetics' class could be taught as three classes (each segment one class) held at three different times but was combined as one for the convenience of the patients.

ANSWER: There can only be one visit for a single episode of care per day. No matter how you slice this class, it is still just **ONE** episode of care and thus, it is only one visit or as in the sited example above, ten visits.

19. **QUESTION**: Does it make a difference to PASBA if the BDC workload is rolled into BDA?

We've been having difficulty getting the pediatric personnel to remember to use BDC when entering well baby check ups. From MEPRS perspectives, what are we doing to ourselves if we stopped coding well baby as BDC and use only BDA? And if you know of consequences other than MEPRS related, please tell me.

ANSWER: There is no impact on either PASBA or MEPRS if the decision is made to eliminate the separate reporting of well baby. However, AMPO recommends this change be made at the beginning of the fiscal year.

20. **QUESTION**: The Stress Lab (DDAA) does EKGs, holter monitors and GXTs. Do we only count an EKG procedure and a clinic visit for GXTs only? The EKGS and the holter monitors are interpreted/read by the doctors. Seems there used to be policy/guidance that we didn't get a clinic visit count unless the physician was present during the procedure. The doctor is present during the GXT and in some cases they may do an EKG. A GXT is a Graded Exercise Test. The EKG technician books the patients in the Stress Lab (EKG) for the GXTs which are scheduled on Mondays and Thursdays. The technician gives the patients written and verbal instructions prior to the procedure. The technician hooks the EKG electrodes to the patient. The EKG machine collects data while the patient is walking on the treadmill and does an EKG every 2 minutes. The doctor is present and monitors the EKG while it is measuring the heart rate. GXTs require about 40 minutes. The doctor is always present. Appointment is made in the EKG clinic. Physician's time is blocked out in his clinic. Can the physician get a clinic visit for the time he spends with this patient?

ANSWER: The Physician should book the GXT in his clinic. The scheduling in the DDAA clinic is purely administrative, as the performance factor for DDAA is "procedure" not "visits".